

Care Coordination Addendum to Written Protocols Between Regional Care Collaborative Organizations (RCCOs) and Single Entry Point Agencies, Behavioral Health, Home Health, and Long-term Services and Supports Providers

Care Coordination Principles and Practices

Long-term care needs of children, seniors and persons with disabilities (SPD) often involve community-based, long-term services and supports (LTSS) different from services delivered by clinical providers. The following person-directed, independent living practices are consistent with the Department of Health Care Policy and Financing (Department) and RCCO policy objectives. LTSS providers are key partners in assisting RCCOs achieve key performance objectives by extending services of acute care providers into home and community settings. Such collaborative efforts are expected to have a positive effect on minimizing unnecessary events (e.g., emergency room visits hospital readmissions).

Common Terminology

- Medical Care and Social Service Coordination - Medical care and social service coordination addresses interrelated medical, social, developmental, behavioral, educational, and financial needs to optimize health and wellness outcomes and opportunities to lead productive lives. Care coordination is a person and family-centered, assessment-driven, team activity designed to meet individual needs and preferences while enhancing the caregiving capabilities of families and service providers in a fiscally responsible way.¹
- Person-centeredness - Person-centeredness involves providing individuals and/or their authorized representative timely, understandable, and actionable information on options related to individual care plans, based on individual strengths, goal setting, and reassessment of options. Individuals and/or their authorized representative use the information to make informed choices about service providers, treatments, community-based living, employment, and social service options.
- Independent Living – Independent living offers seniors and persons with disabilities opportunities to live in the community rather than in an institutional setting and to work, travel, and enjoy social relationships based on decisions they and/or their authorized representatives make. Independent living philosophy asserts that persons with disabilities are the best experts on their needs and should be allowed and encouraged to identify solutions they prefer, to be in charge of their lives, and to speak for themselves. Independent living asserts that persons with disabilities are entitled to pursue independence, inclusion, respect, education, health, housing, proper nutrition, employment, and financial security.

¹ Adapted from Colorado Care Coordination Community of Practice, Aug. 2011, Jan. 2013.

- Self-Direction - In addition to the principles of person-centeredness and independent living, self-direction includes the right to exercise hiring and firing authority over personal care attendants, budgetary decision-making, and choice of living conditions. Consumer Directed Attendant Support Services (CDASS) and Community First Choice (CFC) are two examples of such policy initiatives supported by the Department.²

Recommended Implementation Steps

1. Expertise - RCCOs identify and work to utilize service providers with expertise in the long-term services and supports community, including members, service providers, and advocates. Examples of how LTSS providers with aging and disability expertise may support RCCOs are provided at the end of this Addendum.
2. Cultural Competency Training - Experienced disability trainers provide disability cultural competency training to RCCO leadership, staff, and affiliated providers. RCCOs maintain training completion records in their human resource files.
3. Hiring Criteria - Portions of RCCO care coordination staff, including contract nurses, have a minimum of 3-5 years of experience in community-based LTSS related work (e.g., employment in home health, senior or disability centers or equivalent expertise).
4. Complementary Planning – RCCOs develop a complementary plan of medical, behavioral, and social services with the individual and/or family, including plans to address unmet needs with appropriate providers and/or natural family supports.
5. Service Referrals - RCCOs support the principle of full parity among clinical and social agency decision makers involving LTSS, including decisions about referrals, to assure consideration of the most person-friendly, cost-effective, community-based options.
6. Stakeholders Engagement - RCCOs and LTSS providers hold regular and widely promoted stakeholder meetings to address care coordination issues. RCCOs sponsor a cross-disability advisory council, quarterly disability focus groups, or equivalent group processes to enable individuals, representatives, and advocates assist in identifying care coordination barriers and solutions and to discuss related Department, RCCO, and LTSS standards, processes, outcomes, and metrics.
7. Accessibility of Facilities and Services – RCCOs identify the accessibility of facilities and services on their websites to assist persons with disabilities who are seeking care with information about public transit and parking lots; building access; path of travel; bathroom, examination table and equipment assess; and telephone, video,

² See <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Self-Directed-Services.html> ; <http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1210324172195>; and <http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1251631756927>.

and call center communications consistent with the Americans with Disabilities Act objectives. RCCOs hire or consult with an ADA coordinator to review internal, provider, and interagency accessibility needs related to treatment and care coordination.

8. Information Access – RCCOs ensure that competent signing services are provided for hearing impaired or deaf persons and that alternative media, in addition to printed materials, are available to the extent practical for benefits, services, programs, treatment information and test results, classes, personal health information, and complaint resolution. RCCOs make progress toward Section 508 compliant websites³ and the use of preferred means of communication (e.g., text, phone, letter, email, audio relay for deaf persons).

Core Practices and Information Sharing

Entities providing the majority of services follow core practices identified below for individual clients and/or shared clients. RCCOs and other providers such as case management agencies (CMAs) share information about these practices as part of care coordination and case management communications between providers and the individuals served and their family members.⁴ RCCOs exercise their own approaches in implementing these individual and family-centered practices for seniors and persons with disabilities.

- Engaging family members and advocates as needed.
- Identifying and supporting desired individual and family outcomes.
- Re-assessing and modifying the plan of care with the individual and family as needed.
- Assessing, with the individual and family, individual strengths as well as unmet needs across life domains.
- Identifying sources of referrals and LTSS providers, facilitating connections with these sources, and managing continuous communication across these sources.
- Providing information around purpose and function of recommended treatments, referrals, services, and supports.
- Supporting and facilitating transitions of care.
- Establishing accountability or negotiating responsibility for self-care.

³ See <http://www.hhs.gov/web/508>.

⁴ Adapted from Colorado Care Coordination Community of Practice, Jan. 2013.

- Sharing knowledge and information and facilitating communication among participants in individual and family care.
- Making referrals to competent service providers, including transportation support, who are the shortest distance from the client.
- Conducting activities related to care coordination using related data and data sources, treatment and service prioritization practices, and referral activities based on policies and procedures that are fully transparent to individuals, family members, and their advocates.

Protocol Updates

The Department, RCCOs, providers and partners, stakeholders, and appropriate advisory groups will review these guidelines periodically and not less than annually and update as needed.

How LTSS Providers with Aging and Disability Expertise May Support RCCOs (Examples)

- Program and Service Accessibility Reviews
- Facility Accessibility and ADA Compliance Reviews
- Disability Cultural Competency Training for Boards, Organizations, and Providers
- Life Adjustment Training for the Newly Disabled
- Coordination Team Analyses and Reviews
- Participation in Advisory Groups, Committees, and Other Advocacy Forums